CENTER FOR HEALTH INFORMATION AND ANALYSIS
2015 ANNUAL PREMIUMS DATA REQUEST
FREQUENTLY ASKED QUESTIONS
Updated: February 12, 2015

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Premiums & Claims

1. What is the definition of the "**Administrative Service Fees"?**
   The administrative service fees are the fees earned by the TPA for the full administration of a self-insured health plan; this excludes any premiums for stop-loss coverage.

2. What does an "**Adjusted Premium**" show?

   Adjusted premium accounts for changes in demographics, geographic area, benefits, and group size to calculate premium trends on a consistent basis.

3. How will **payer-specific rating factors** be used in the "**Adjusted Premium**" calculations?
   Payer-specific factors provide the best indicator of payer-specific adjusted premiums and trends. CHIA is, however, considering alternative ways of combining payer data to most accurately represent market average adjusted premiums.

4. What is the definition of "**Allowed Claims**"?

   Allowed claims are the total cost of claims after the provider or network discount, if any. Allowed Claims are equal to Incurred Claims plus member cost sharing; this should include medical claims, drug claims, capitation payments, and all other payments to providers, including those paid outside of the claims system. This value should include estimates of completed claims for periods that are not yet considered complete.

   For this Request, run-out beyond March 2015, as available, should be noted and estimated for outstanding claims incurred during calendar years 2012 through 2014. This value should not include medical management expenses for medical management performed in-house or by third parties other than the providers, or any other payments to other entities besides the providers.

5. What are the definitions of "**In-network**" and "**Out-of-network**"?
   In-network claims are allowed/incurred claims from providers with which the member's plan has or leverages a contractual agreement and negotiated rates.

   Out-of-network claims are allowed/incurred claims from providers with which the member's plan <u>does not</u> have or leverage a contractual agreement or negotiated rates.

   The in- vs. out-of-network determination is made according to how benefits are administered to the member. If the reporting entity contracts with another entity to use the latter's network, and a member of the reporting entity receives services from a provider in that network that are covered at in-network benefit and cost sharing levels, the associated claim would be considered in-network.

6. Is **reporting done on a calendar or policy year basis**?

   Reporting is done on a calendar year basis.

7. How is the "**Percent of Benefits Not Carved Out**" calculated?

   The percent of benefits not carved out must be estimated when the reporting entity does not have access to the actual data for benefits that are carved out to another vendor. A simplified example is provided below.

   - *1,000 members have comprehensive coverage provided by the reporting entity*
   - *500 members have only medical coverage provided by the reporting entity; pharmacy coverage is carved out to a pharmacy benefits manager*
   - *Based on those members that have comprehensive coverage with the reporting entity, it is known that in 2014 80% of total allowed claims were for medical services and 20% of total allowed claims were for pharmacy services. These percentages should be calculated in aggregate across all market sectors, funding type, managed care types, and product types for a given*

calendar year. If the reporting entity lacks sufficient data for members with comprehensive coverage, it may combine its data with that of any affiliated entities.

*The 2014 Percent of Benefits Not Carved Out for this segment is 93%. (1,000 * 100% + 500 * 80%) / (1,000 + 500) = 93%.*

8. How will the "**Percent of Benefits Not Carved Out**" value be used for analytic purposes?
CHIA may calculate an "all-inclusive" premium or premium equivalent using this value. Any premium figures reported in this way will be identified explicitly as such. The premium equivalent field that is calculated by the template does not use this value in the calculation.

Group Size Classifications

9. When discussing our **rating factors**, what "**group size" definitions** should we use?

Only as related to rating factors, payers should define group size ranges as they would apply their rating factors.

10. How do we determine the **group size parameters**? Do we use the actual numbers in the template for reporting any groups that fall into those categories?

Below is a listing of Market Sector definitions used throughout the request:

a. *Individual*
b. *Small Group*
    i. *Fully-Insured (1-50 eligible enrollees, see 211 CMR 66.04)*
    ii. *Self-Insured (1-50 enrolled employees)*
c. *Mid-Size Group (51-100 enrolled employees)*
d. *Large Group (101-499 enrolled employees)*
e. *Jumbo Group (500+ enrolled employees)*

In the fully-insured Small Group market sector, please include only those small employers that meet the definition of "Eligible Small Business or Group" per Massachusetts Division of Insurance Regulation 211 CMR 66.04. In addition, fully-insured employers that have fewer than 51 enrollees, but do not meet the definition of an "Eligible Small Business or Group", should be included in the Mid-Size Group.

11. Are these "**market sector" definitions** consistent with prior years?

Yes. Small Group, as defined by regulation, is defined by number of eligible employees. If it doesn't satisfy 211 CMR 66.00, but has fewer than 51 enrolled employees, then it should be classified as Mid-Size Group. Larger groups (Mid-Size, Large, Jumbo) are defined by number of enrolled employees. In the self-insured segment of the market, we are clarifying this year that all employer-based market sectors are determined based on the number of enrolled employees. A self-insured employer with 40 enrolled employees would therefore be classified as a Small Group regardless of the number of eligible employees.

12. How is the "**Average Employer Size"** calculated when an employer has members in multiple Managed Care Type and/or Product Type categories?

The average employer size would be calculated by taking the weighted average of the total group size where the weighting is done based on the number of employees in the given category. An example of how the calculation would be done if an employer has employees in multiple categories under Managed Care Type is shown below:

	Employees		
Employer Group	HMO	PPO	Total
A	200	50	250
B	0	300	300
C	75	200	275
D	150	0	150
Avg Employer Size	219.1	286.4	243.8

219.1 = (200*250 + 0*300 + 75*275 + 150*150)/(200 + 0 + 75 + 150)
286.4= (50*250 + 300*300 + 200*275 + 0*150)/(50 + 300 + 200 + 0)

Geographic Area Calculations

13. What is **Geography** used for?

    Geography is used to remove the impact that geographic shifts may have on a premium trend. It may also be used to display membership totals across the state at the three-digit zip-code level.

14. For **Member Months by Geographic Area** (Tabs A1 and A2), should we use the **3 digit zip code based on the member's address**? Is this different from previous years?

    This is consistent with the 2014 Request when the change was made to request member zip code rather than employer zip code.

Managed Care Type & Product Type

15. What is the difference between **Managed Care Type** and **Product Type**?

    Managed Care Type is dependent on network/provider coverage. Product Type is dependent on certain cost sharing features, either the deductible level (HDHP) or tiered cost sharing within a network (Tiered Network).

16. What are examples of **HMO, PPO, and "Other" plans**?
    HMO plans utilize a closed network of providers, where selecting a PCP may be required; referrals may be needed to see specialists. PPO plans have a network of preferred providers; allow coverage outside that network (at a higher cost); do not require referrals; and a primary care physician is not necessary. "Other" plans are those that do not fall into the HMO or PPO categories. An example of an "Other" plan would be Indemnity plans. See Definitions for more information.

17. Is **HMO/ PPO defined solely by whether a member is assigned a PCP**? What if a member is assigned a PCP, but has a more open network (such as with tiering)?

    HMO/PPO split is not solely dependent on whether a member is assigned a PCP.

18. **HMO v. PPO is measured by dollar value**, not volume of claims, is this correct?

    That is correct.

19. Can you provide additional clarification on how to classify by **Managed Care Type**?

    The determination of managed care type should be done at the member level, as based on the benefit plan selected by the member, not the employer level.

    The following example shows how multiple plans under one employer would be grouped into the different managed care type buckets. Please note that the "member months" field in the tables below includes both employees and dependents. Plans 1-3 are fairly

straight-forward as there is only one managed care type for each of those plans, HMO, PPO, and Other respectively. Plan 4,however, a POS plan that combines HMO and Indemnity components, has multiple managed care types at the member level and, as a result, it would be grouped into the managed care type with the most allowed dollars, which is shown in the "Plan 4 Detail" table. The Plan 4 Detail table contains the allowed claims experience for ALL members covered under that plan, such that all members in the plan are reported under the same managed care type even if a subset of the members experience an allowed claims percent that would result in a different managed care type if measured at the member level. In this example, Plan 4 would be considered HMO, since the HMO managed care type had the most allowed dollars, and would be grouped under HMO for all reporting (membership, premium, claims, etc.).

For this one employer with four plans, the summation by managed care type is shown in the "Final Managed Care Type Information" table below.

EXAMPLE OF MULTIPLE PLANS FOR ONE EMPLOYER

Plan	Description	Member Months	Allowed Claims	Premium
1	HMO	180	$54,000	$67,500
2	PPO	120	$44,100	$42,000
3	Indemnity	96	$30,240	$43,200
4	POS	48	$14,000	$19,200

Plan 4 Detail		
Plan Type	**Allowed $**	**Allowed Pct**
HMO	$9,000	64.3%
Indemnity	$5,000	35.7%

Since the majority of allowed claims for plan 4 fall under HMO, it is considered HMO for all reporting (membership, premium, claims, etc.)

Final Managed Care Type Information				
Final Managed Care Type	**Grouping**	**Members**	**Allowed Claims**	**Premium**
HMO	Plans 1 & 4	228	$68,000	$86,700
PPO	Plan 2	120	$44,100	$42,000
Other	Plan 3	96	$30,240	$43,200

Throughout the definition of Managed Care Type, references to "plan" refer to a health benefit plan which is a unique set of network and cost sharing structure. For example, a payer's plans might include the payer's "Broad Network Silver HMO $1,000" and "Broad Network Bronze PPO $5,000." The term "plan" is not intended to refer to an employer arrangement.

20. **HDHPs may also be paired with HSAs and HRAs** to make plans more affordable for employees. Will CHIA note this?

    CHIA will note that the data does not account for corresponding employer HRA or employee HSA adoption, which may mitigate out of pocket expenses.

21. Groups that offer a **High Deductible Health Plan (HDHP) options** should be reflected under the HDHP option, even if only a small minority of members are actually covered. Is this accurate?

    Product type, just like managed care type, is determined at the member level, as based on the benefit plan selected by the member, not the employer level, as based on the benefit plan selected by the member. Only members covered under the HDHP should be included. For example, if an employer has 40 members, but only 5 are on a HDHP, only those 5 should be included in the HDHP membership counts.

22. Should **limited network plans** be reported under **the Tiered Network** Product Type category?

Limited network plans typically have a provider network that is a subset of the payer's general provider network. If members of a limited network plan can still access services from providers outside of the limited network and they are still considered in-network, just at higher levels of cost-sharing (e.g. $1,000 inpatient admission copay instead of a $500 copay), then this plan would be considered a Tiered Network plan. Similarly, if the plan has multiple tiers within its limited network, it would be considered a Tiered Network plan. If, however, the plan considers providers in the payer's general provider network but not in the limited network as out-of-network providers, the plan would not be considered to have a Tiered Network.

If the payer offers a plan with only one level of cost sharing per type of service (e.g., $1,000 inpatient admission copay), but offers it with a network that is a subset of the payer's general provider network, then this is a limited network plan and not a tiered network.

Data Reconciliation

23. If we do not have any **previous CHIA premium data reports to reconcile against** should we leave this section blank?

    Since this is your first submission, this Tab (E2) does not need to be completed. However, please provide a response for Tab (E1) that reconciles the information provided to the "Annual Comprehensive Financial Statement," "Medical Loss Ratio Reporting Form," and "Supplemental Health Care Exhibits" data.

24. **What is the submission time period we need to reconcile to**?

    For past Premium Request data, 2012 and 2013. For the "Annual Comprehensive Financial Statement," "Medical Loss Ratio Reporting Form," and the "Supplemental Health Care Exhibits" data, please reconcile to-be-submitted Premiums-data for 2012, 2013, and 2014, with the last, as publicly available as of the submission date (May 2015).

Template Use

25. Do we have to use the **Excel template**?

    Yes.

26. Who should we contact if we have **questions on the template**?

    Contact Dianna Welch for technical questions at dianna.welch@oliverwyman.com .

Other Questions

27. For Specification C, is CHIA looking for information by payer **rating size bands**? Is it okay to populate the spreadsheet using our rating bands?

    That is correct. Payers should populate the spreadsheet with their own rating bands. Please see the bolded instructions in cell A7 of Tab C.

28. Merged market plans underwent significant changes starting January 1, 2014 to comply with the Affordable Care Act. What is the **value of requiring data on plans back to 2012**?

    Historical information is used to calculate adjusted premiums, which account for changes in demographics, geographic area, benefits, and group size, which allow for a properly calculated premium trend.